SECTION 8 RESOLVING DENIED CLAIMS

Claim adjustments

Resubmission of a Denied Claim

The Medicaid Claim Adjustment form is used to adjust a previously paid claim or a denied claim. If your paid or denied claim was for one of the EOBs listed at the end of this section, do NOT file as a Medicaid Adjustment; these claims can be refiled as new claims. If your EOB is not listed below please use the Medicaid Claim Adjustment Request form to process your claim. Do not use the Medicaid Claim Adjustment form to inquire about the status of a claim or to submit a claim for dates of service that have exceeded the filing time limit. Please use the Medicaid Resolution Inquiry form if you have exceeded the filing time limit.

When submitting adjustment requests, always attach a copy of any Remittance and Status Report (RA) related to the adjustment as well as any medical records that could justify the reason for paying a previously denied claim. It is suggested that providers include a corrected claim when submitting an adjustment but it is not required if the claim was filed electronically.

Within 30 days of filing a Medicaid Claim Adjustment Request form, the status of the claim will be listed on the RA as "pending". If the status code does not appear as pending, verify that the recipient's Medicaid identification (MID) number and the internal claim number (ICN) are complete and correct. If the MID number or ICN is incorrect, refile the adjustment request with the correct information.

Instructions for Completing the Medicaid Claim Adjustment Request Form

The instructions for completing the Medicaid Claim Adjustment Request are listed below. A copy of the Medicaid Claim Adjustment form is in Appendix G-27 and on the DMA's Web site at **http://www.dhhs.state.nc.us/dma/forms.html.**

Line	Instruction
Provider Number	Indicate the billing provider's number.
Provider Name	Enter the name of billing provider.
Recipient Name	Enter the recipient's name exactly as it appears on the MID card.
Recipient ID	Enter the recipient's MID number as it appears on the MID card.
Claim Number	Enter the ICN followed by the 5-character financial payer code as indicated on the RA. Always reference the original ICN even if you have a subsequent denied adjustment. For an adjustment that has a payment on a detail, reference the adjustment ICN as the claim number.
Date of Service	Enter the beginning and the ending date of service covered on the original claim.
Billed Amount	Enter the amount billed on original claim.
Paid Amount	Enter the amount paid on the original claim.

Line	Instruction
RA Date	Enter the date the original claim was paid.
Type of Adjustment	Indicate reason for the adjustment (i.e., overpayment, full recoupment, etc.).

Change or Corrections to be Made	**Units**	Indicate the correct number of units.
	Dates of Service	Indicate the correct date of service.
	Third Party Liability	Indicate TPL amount on the adjustment form and include a copy of the TPL voucher showing payment.
	Procedure/ Diagnosis Code	Indicate the combined procedure code or revenue code and the corrected billed amount.
	Patient Liability	Include the latest Patient Monthly Liability form (DMA-5016) pertaining to the date of service. Include all related RAs showing a liability amount applied to the claim. The adjustment request will be reviewed by DMA's Claims Analysis Unit. If your RA indicates and EOB 9607 Adjustment being reviewed for change in patient liability, do not refile the adjustment, it will be processed for you, do not resubmit the adjustment. DMA resubmits these adjustments for the provider.
	Medicare Adjustment	Attach the original and the adjusted Medicare vouchers. Use the ICN for the previously paid claim for the claim referenced on the adjustment form. Indicate all related Medicare vouchers. If Medicare processing necessitates an adjustment payment on two separate claims, the provider should send both claim copies and both Medicare vouchers. Use the ICN for the denied duplicate claim for the claim references on the adjustment form.
	Billed Amounts	Indicate the total billed amount on the adjustment request form. Do not use the difference of the original claim and the adjusted claim as the billed amount.
	Further Medical Review	Submit only the medical records, operative notes, anesthesia records, etc., that may affect the claims payment. These records

Line	Instruction	
		are used by medical staff to determine whether to reimburse the providers or deny the adjustment as paid correctly.
	Other Duplicate Denials	When filing an adjustment for a duplicate denial for a CMS-1500 claim, attach medical records or radiology reports for the dates of service in question. Do not submit the adjustment form or medical records with front and back copies. All records and forms are scanned on front side only.
Specific Reason for Adjustment Request	Indicate the reason for the adjustment. If the adjustment is a result of procedures not being combined, indicate the codes that are being combined. If the adjustment is necessitated by incorrect units, indicate the total number of correct units as it should have appeared on the original claim along with the corrected billed amount and the correct date of service.	
Signature of Sender	Indicate the name of the person filling out the form.	
Date	Indicate the date the adjustment request is submitted or mailed.	
Phone number	Indicate the area code and telephone number for the person filling out the form.	

Tips for Filing Adjustments

The following tips will assist in completing the adjustment form.

- Complete only one adjustment form per claim; a separate adjustment request form for each line item on a single claim is not necessary.
- Reference only one ICN per adjustment form.
- If requesting a review of a previously denied adjustment, reference the original ICN and resubmit with all supporting documentation related to the adjustment. Do not reference the ICN for the denied adjustment.
- Include a copy of the appropriate RA with each adjustment request. If multiple RAs were involved in the claim payment process, include copies of each RA.
- Include a copy of the claim that is referenced on the adjustment request.
  Note: This is not required for electronically submitted claims.
- When the adjustment request involves a corrected or revised claim, send both the original and revised claim. Do not obliterate previously paid details on the claim.
- Include pertinent information on a separate sheet of paper. Do not write information on the back of the adjustment form, RAs, etc.
- Ensure that all of the information submitted with the adjustment request is legible.
- Send only the medical records that pertain to the services rendered. If it is necessary to send records with other information included, identify the portion of the record that is significant to the adjustment request.
- Only the claim that pertains to the payment or denial in question should be submitted with the adjustment request. Do not submit any other claims with the adjustment request.

Claims for service dates that have not been submitted should be filed on a new day claim, including late charges for codes not previously filed.

- When submitting an adjustment to Medicaid due to a Medicare adjusted voucher, attach both the original voucher and the adjusted Medicare voucher. Reference the ICN of the original voucher.
- If requesting a review of a previous partial payment or a partial recoup adjustment, reference the ICN for the adjustment and resubmit with all supporting documentation related to the adjustment.

The most common mistakes that are made when filing adjustments are:

- Incomplete or invalid MID information or ICNs.
- Multiple ICNs on the same form.
- The reason for the adjustment request is not specified or it is too general.
- A copy of the RA related to the request is not included when the form is submitted.
- The original ICN is not referenced on the form or a denied adjustment ICN is used.
- A partial payment or partial recoupment number is not referenced as the original ICN.
- The adjustment is filed after the 18-month time limit.
  Note: If an adjustment is not filed until the 17th month from the date of service, the original claim may no longer be available in the system for adjustment. Submit adjustments as soon as possible so they can be processed within the 18-month time limit.
- Required documentation is missing from the adjustment request (i.e., Medicare vouchers, medical records, operative records, etc).

RA requirements for Paper Adjustments:

- Paper adjustment processing procedures require that providers attach a copy of all paper Medicaid Remittance Advice (RA) page(s) related to the referenced claim.
- A provider generated RA is not an acceptable substitute for the paper copy mailed to providers by EDS. These generated RAs have varied formats and do not include all information necessary for manual adjustment processing.
- Paper adjustments that do not include the required RA will be denied with EOB 812, "Adjustment denied. Please refile with all related R/A's, including original processing." Providers receiving this denial should resubmit a copy of their adjustment with the requested RA.
- If you do not have a copy of the paper R/A, please contact EDS Provider Services to request a replacement. (There is a per page charge for RA requests that are more than 10 checkwrites from date requested. RA reprints for the last 10 checkwrites are provided at no charge.)

Submitting an Adjustment Electronically

With the implementation of HIPAA standard claims transactions, adjustments may now be filed electronically. There are two separate actions that may be filed:

1. Void – in order to file a claim to be voided, the provider must mark the claim as a voided claim using the Claim Submission Reason Field (Dental and CMS-1500) and Type of Bill (UB-94) on the 837 electronic claim transaction. The ICN for the original claim to be voided must also be provided. When processed, the claim associated with the original

ICN will be recouped from the patient's record and the payment will be recouped from the providers RA.

2. Replacement – a replacement claim may be filed by completing a corrected electronic claim and marking the claim as a replacement using the Claim Submission Reason Field (Dental and CMS-1500) and Type of Bill (UB-94) on the electronic claim transaction. The ICN for the original claim to be replaced must also be provided. The original claim will be recouped from the patient's record and shown as a recoupment on the RA when the replacement claim processes and pays without error. If the replacement claim denies, the entire replacement process will deny, including the recoupment.

Paper adjustments will continue to be accepted and processed by N.C. Medicaid. Although adjustments may be filed electronically, providers are advised to file adjustments on paper when paper documentation is required.

Pharmacy Claim Adjustments

A Pharmacy Adjustment Request form is available for providers to use to request an adjustment to a Medicaid payment when the adjustment cannot be processed online. This form is used to request an adjustment to a Medicaid payment for prescription drugs. Claims that are denied with no payment can be resubmitted instead of adjusted. Use the Pharmacy Adjustment Request form to:

- credit Medicaid for a billed and paid prescription that was never dispensed
- credit Medicaid for a billed and paid prescription for unit-dose drugs that were unused
- correct Pharmacy of Record denials when submitted with a copy of the Medicaid card stub
- Correct NDC , Quantity, Days Supply, Date of Service, Billed Amount, RX number, Third Party Payment

Instructions for Completing the Pharmacy Adjustment Request Form

The instructions for completing the Pharmacy Adjustment Request form are listed below. A copy of the Pharmacy Request form is in Appendix G-30 and on DMA's Web site at http://www.dhhs.state.nc.us/dma/forms.htm.

Line	Instruction
Recipient Medicaid Number	Enter the recipient's MID number as it appears on the MID card.
Recipient Name	Enter the recipient's name exactly as it appears on the MID card.
Pharmacy Name and Provider Number	Enter the name of the pharmacy and the pharmacy's Medicaid provider number.
Rx Number	Enter the prescription number assigned by the pharmacy to the prescription on claim to be adjusted.
Drug Name	Enter the name of the drug dispensed including the strength and the dosage form (abbreviated).
NDC	Enter the 11-digit NDC for the prescription.

Quantity	Enter the original quantity to be billed using up to five digits.
Billed Amount	Enter the original total to be billed for the prescription claim.
Date Filled	Enter the original date the prescription was filled using the MM/DD/YY format.
Claim Number	Enter the ICN of the claim that is submitted to be adjusted.
Denial EOB	Do not enter information in this block unless the claim was denied with EOB 0985 *Exceeding Prescription Limitation*
Insurance Paid	Indicate a correction of omission of Other Payer Amount by placing an "X" in this box. Indicate in the "Adjustment Reason" block that the adjustment request is for an omission of Other Payer Amount. Attach appropriate documentation of the other payer amount to the adjustment request.
Adjustment Reason	State why a correction is needed.
Paid Amount	Enter the amount of the original Medicaid payment for the claim identified by the ICN listed in the "Claim Number" block.

EOB Denials that Do Not Require Filing an Adjustment

In most situations, if one of the following EOBs is received providers should refile the claim with correct information. If adjustments are submitted for the EOBs below, the claim will be denied for EOB 998 which states "Claim does not require adjustment processing, resubmit claim with corrections as a new day claim" or EOB 9600 which states "Adjustment denied; if claim was with adjustment it has been resubmitted. The EOB this claim previously denied for does not require adjusting."

In the future, resubmit a new or corrected claim in lieu of sending an adjustment request". Also, if a claim does receive an EOB that is not included on this list, do not automatically file an adjustment because that may not be how that specific claim situation should be resolved. Please contact EDS Provider Services at 1-800-688-6696 or 919-851-8888 if there are any questions on how to resolve a specific denial (Last Revision 12/15/04).

0002	0003	0004	0005	0007	0009	0011	0013	0014	0017
0019	0023	0024	0025	0026	0027	0029	0033	0034	0035
0036	0038	0039	0040	0041	0042	0046	0047	0049	0050
0051	0058	0062	0063	0065	0067	0068	0069	0074	0075
0076	0077	0078	0079	0080	0082	0084	0085	0089	0090
0093	0094	0095	0100	0101	0102	0103	0104	0105	0106
0108	0110	0111	0112	0113	0114	0115	0118	0120	0121
0122	0123	0126	0127	0128	0129	0131	0132	0133	0134
0135	0138	0139	0141	0143	0144	0145	0149	0151	0153
0154	0155	0156	0157	0158	0159	0160	0162	0163	0164
0165	0166	0167	0170	0171	0172	0174	0175	0176	0177
0179	0181	0182	0183	0185	0186	0187	0188	0189	0191

0194	0195	0196	0197	0198	0199	0200	0201	0202	0203
0204	0205	0206	0207	0208	0210	0213	0215	0217	0219
0220	0221	0222	0223	0226	0227	0235	0236	0237	0240
0241	0242	0244	0245	0246	0247	0249	0250	0251	0253
0255	0256	0257	0258	0270	0279	0282	0283	0284	0286
0289	0290	0291	0292	0293	0294	0295	0296	0297	0298
0299	0316	0319	0325	0326	0327	0356	0363	0364	0394
0398	0424	0425	0426	0427	0428	0430	0435	0438	0439
0452	0462	0465	0505	0511	0513	0516	0523	0525	0529
0536	0537	0548	0553	0556	0557	0558	0559	0560	0569
0572	0574	0575	0576	0577	0578	0579	0580	0581	0584
0585	0586	0587	0588	0589	0590	0593	0604	0607	0609
0610	0611	0612	0616	0620	0621	0622	0626	0635	0636
0641	0642	0661	0662	0663	0665	0666	0668	0669	0670
0671	0672	0673	0674	0675	0676	0677	0679	0680	0681
0682	0683	0685	0688	0689	0690	0691	0698	0732	0734
0735	0749	0755	0760	0777	0797	0804	0805	0814	0817
0819	0820	0822	0823	0824	0825	0860	0863	0864	0865
0866	0867	0868	0869	0875	0888	0889	0898	0900	0905
0908	0909	0910	0911	0912	0913	0916	0917	0918	0919
0920	0922	0925	0926	0927	0929	0931	0932	0933	0934
0936	0940	0941	0942	0943	0944	0945	0946	0947	0948
0949	0950	0952	0953	0960	0967	0968	0969	0970	0972
0974	0986	0987	0988	0989	0990	0991	0992	0995	0997
0998	1001	1003	1008	1022	1023	1035	1036	1037	1038
1043	1045	1046	1047	1048	1049	1050	1057	1058	1059
1060	1061	1062	1063	1064	1078	1079	1084	1086	1087
1091	1092	1152	1154	1156	1170	1175	1177	1178	1181
1183	1184	1186	1197	1198	1204	1232	1233	1275	1278
1307	1324	1350	1351	1355	1380	1381	1382	1396	1399
1400	1404	1422	1442	1443	1502	1506	1513	1866	1868
1873	1944	1949	1956	1999	2024	2027	2147	2148	2149
2235	2236	2237	2238	2270	2335	2911	2912	2913	2914
2915	2916	2917	2918	2919	2920	2921	2922	2923	2924
2925	2926	2927	2928	2929	2930	2931	2944	2988	3001
3002	3003	5001	5002	5201	5206	5216	5221	5222	5223
5224	5225	5226	5227	5228	5229	5230	6703	6704	6705
6707	6708	7700	7701	7702	7703	7705	7706	7707	7708
7709	7712	7717	7733	7734	7735	7736	7737	7738	7740
7741	7788	7794	7900	7901	7904	7905	7906	7907	7908
7909	7910	7911	7912	7913	7914	7915	7916	7917	7918

7919	7920	7921	7922	7923	7924	7925	7926	7927	7928
7929	7930	7931	7932	7933	7934	7935	7936	7937	7938
7939	7940	7941	7942	7943	7944	7945	7946	7947	7948
7949	7950	7951	7952	7953	7954	7955	7956	7957	7958
7959	7960	7961	7962	7963	7964	7965	7966	7967	7968
7969	7970	7971	7972	7973	7974	7975	7976	7977	7978
7979	7980	7981	7982	7983	7984	7985	7989	7990	7991
7992	7993	7994	7995	7996	7997	7998	7999	8174	8175
8326	8327	8328	8400	8401	8901	8902	8903	8904	8905
8906	8907	8908	8909	9036	9054	9101	9102	9103	9104
9105	9106	9174	9175	9180	9200	9201	9202	9203	9204
9205	9206	9207	9208	9209	9210	9211	9212	9213	9214
9215	9216	9217	9218	9219	9220	9221	9222	9223	9224
9225	9226	9227	9228	9229	9230	9231	9232	9233	9234
9235	9236	9237	9238	9239	9240	9241	9242	9243	9244
9245	9246	9247	9248	9249	9250	9251	9252	9253	9254
9256	9257	9258	9259	9260	9261	9268	9269	9272	9273
9274	9275	9291	9295	9600	9611	9614	9615	9625	9630
9631	9633	9642	9684	9801	9804	9806	9807	9919	9947
9993									

Note: This list is not all-inclusive.

Resolution Inquiries

The Medicaid Resolution Inquiry form is used to submit claims for:

- time limit overrides
- Medicare overrides
- third party overrides

When submitting inquiry requests, always attach the claim and a copy of any RAs related to the inquiry request, as well as any other information related to the claim. Each inquiry request requires a separate form and copies of documentation (vouchers and attachments). Because these documents are scanned for processing, only single-sided documents should be attached to the inquiry request. **Do not attach double-sided documents to the inquiry request**. A copy of the **Medicaid Resolution Inquiry form** is in Appendix G-29 and on DMA'S Web site at http://www.dhhs.state.nc.us/dma/forms.html.

Time Limit Overrides

All Medicaid claims, except hospital inpatient and nursing facility claims must be received by EDS within 365 days of the **first date** of service in order to be accepted for processing and payment. All Medicaid hospital inpatient and nursing facility claims must be received within 365 days of the last date of service on the claim. If a claim was filed within the 365-day time period, providers have 18 months from the RA date to refile a claim.

If the claim was initially received and processed within the 365-day time limit, that claim can be resubmitted on paper or electronically as a new day claim. The new day claim must have an exact match of recipient MID number, provider number, from date of service, and total billed. Claims that do not have an exact match to the original claim in the system will be denied for one of the following EOBs:

0018 Claim denied. No history to justify time limit override. Claims with proper documentation should be resubmitted to EDS Provider Services Unit.

8918 Insufficient documentation to warrant time limit override. Resubmit claim with proof of timely filing – a previous RA, time limit override letter, or other insurance payment or denial letter within the previous six months.

Because DMA and EDS must follow all federal regulations to override the billing time limit, requests for time limit overrides must document that the original was submitted within the initial 365-day time period. Examples of acceptable documentation for time limit overrides include:

- Dated correspondence from DMA and EDS about the specific claim received that is within 365 days of the date of service.
- An explanation of Medicare benefits or other third party insurance benefits dated within 180 days from the date of Medicare or other third party payment or denial.
- A copy of the RA showing that the claim is pending or denied. The denial must be for reasons other than time limit.

The billing date on the claim or a copy of an office ledger is no acceptable documentation. The date that the claim was submitted does not verify that the claim was received by EDS within the 365-day time limit.

If the claim is a Crossover from Medicare or any other third party commercial insurance, regardless of the date of service on the claim, you have **180** days from the EOB date listed on the explanation of benefits from that insurance (whether the claim was paid or denied) to file the claim to Medicaid. You must include the Medicaid Resolution Inquiry Form, copy of the claim, and a copy of the Third Party or Medicare explanation of benefits in order to request a time limit override.

If a claim is submitted for processing beyond the 365-day time limit, attach the claim and required documentation to the Medicaid Resolution Inquiry form and mail to the address indicated on the inquiry form.

Instructions for Completing the Medicaid Resolution Inquiry Form

The instructions for completing the Medicaid Resolution Inquiry form are listed below. A copy of the **Medicaid Resolution Inquiry form** is in Appendix G-29 and on DMA's Web site at http://www.dhhs.state.nc.us/dma/forms.html.

Line	Instruction
Provider Number	Enter the billing provider's number.
Provider Name and Address	Enter the name and address of the billing provider.

Recipient Name	Enter the recipient's name exactly as it appears on the MID card.
Recipient ID	Enter the recipient's MID number as it appears on the MID card.
Date of Service	Enter the beginning and the ending date of service.
Claim Number	If the claim was previously processed, enter the ICN followed by the 5-character financial payer code as indicated on the RA. If this is the first submission, this information is not required.
Billed Amount	Enter the amount billed on the claim.
Paid Amount	If applicable, enter the amount paid on original claim.
RA Date	If applicable, enter the date the original claim was paid.
Specific Reason for Inquiry	Indicate the reason for the inquiry (i.e., time limit override, TPL override, Medicare override). Identify attachments (i.e., RAs, medical records, TPL or Medicare vouchers, etc.).
Signature of Sender	Indicate the name of the person filling out the form.
Date	Indicate the date the adjustment request is submitted or mailed.
Phone number	Indicate the area code and telephone number for the person filling out the form.

Recoupments

Automatic Recoupments

If previously paid claims would cause a current claim to deny during the audit review, EDS will initiate an adjustment to recoup the previously paid charges. This procedure ensures proper payment of services rendered. The following list includes, but is not limited to, examples of automatic recoupments:

- A current claim is filed for dialysis treatment, which includes previously paid charges. EDS will initiate an adjustment to recoup the previous payments in order to pay the dialysis treatment code (i.e., lab, supplies, etc).
- A hospital files an inpatient claim on the same date of service as an outpatient claim. EDS will recoup the outpatient charges to pay the inpatient claim.
- A physician submits a claim and is paid for lab services that were performed at an independent lab. The independent lab also files a claim, which denies as a duplicate. EDS will initiate an adjustment to recoup the charges paid to the attending physician for the lab services and pay the claim submitted by the independent lab.
- The assistant surgeon's or anesthesiologist's claim is filed without the appropriate modifier and is paid as though it were the primary surgeon, subsequently causing the primary surgeon's claim to deny as a duplicate. When an adjustment request is received from the primary surgeon, EDS will initiate a recoupment of the incorrect payment from the assistant surgeon or the anesthesiologist in order to pay the surgeon. The assistant surgeon or anesthesiologist must then submit a corrected claim with the appropriate modifiers.

Provider Refunds

Overpayments, third party reimbursements, and incorrect claim submissions may occur in the processing of Medicaid claims. The following section explains the Medicaid refund process. If the provider is not aware of other insurance coverage or liabilities for the recipient until after the receipt of Medicaid payment, the provider must still file a claim with the health insurance company, then refund to Medicaid the lesser of the two amounts received.

For example:

amount billed by provider to Medicaid	$50.00
amount paid by Medicaid	40.00
amount paid by private insurance	45.00
amount to be reimbursed to Medicaid	$40.00

Refunds are submitted in accordance with the following instructions:

1. Highlight on the RA the appropriate recipient, claim information, and dollar amount of the refund to apply to that recipient.
2. Attach a copy of the RA to the check.
   If a copy of the RA is not available, document the information listed below by whatever means are available and include it with the check. This information is required in order to apply the funds against the correct provider claim and recipient history.

- provider number
- recipient name and MID number
- ICN
- date(s) of service
- dollar amount paid
- dollar amount of refund
- reason for refund (brief explanation)

3. Make the refund check payable to EDS.
   Note: If the refund is in response to a written request from DMA, make the refund check payable to DMA and mail it to the address indicated in the refund request letter.
4. Mail the refund with the requested information to:

   EDS
   ATTN: Finance
   P.O. Box 300011
   Raleigh, NC 27622-3011

Once refunds are entered into the system, the following data will appear on the next RA distributed to the provider:

- The Financial Items section will contain a listing of refunds issued and processed for the provider. EOB 0113 is indicated for any refund transaction.
- The Credit Amount field in the Claims Payment Summary will indicate the total amount of refund(s) processed, thereby giving credit for the returned funds. As a result of returning those funds, the "Net 1099 Amount" field is decreased by the refund amount to ensure the IRS is informed of the correct amount of monies received and kept by the provider. Refund transactions do not affect the Claims Paid, Claims Amount, Withheld Amount or Net Pay amount fields in this section